Maricopa County

Group Insurance Enrollment/Change Form

Please Print

Employee Information

Request Alternative Identification # ☐ Yes ☐ No	Social Security Number (voluntary)	Employee Identification #			
Last Name	First Name	MI	Date of Birth	❑ Male ❑ Female	❑ Married ❑ Single
Mailing Address		City	State	Zip Code	
Home Phone	Work Phone and/or Pager Number	Email Address		Department Name	

Reason For Completing Form (check one)

❑ **New Hire**

❑ **Open Enrollment**

❑ **Change** — Please Check a Reason Below

Add a Dependent
- ❑ Marriage
- ❑ Birth
- ❑ Adoption of child
- ❑ Legal Guardianship of child
- ❑ Qualified medical child support order
- ❑ Other _____

Remove a Dependent
- ❑ Divorce (date of divorce)
- ❑ Legal Separation
- ❑ Death
- ❑ Dependent child reaches limiting age of contract
- ❑ Other _____

Employment Change
- ❑ Change of Spouse s employment
- ❑ Either you or your spouse switched from part-time to full time or vice versa
- ❑ A significant change in your spouse s employer s insurance plan
- ❑ Other _____

❑ **Other** — Please Check a Reason Below
- ❑ Unpaid Leave of Absence
- ❑ Return from Unpaid Leave
- ❑ Return from Military Leave
- ❑ Name Change
- ❑ Address Change
- ❑ Beneficiary Change
- ❑ Court Order
- ❑ Other- can include information about self or dependent._____

Medical Plans

Includes Avesis Vision plan and United Behavioral Health plan.

CIGNA Includes Walgreens Health Initiatives (RX)

Plans	FT	PT
❑ HMO	009	P09
❑ POS	007	P07
❑ PPO	010	P10

HealthSelect

Plan	FT	PT
❑ Health Select	004	PO4

Level of Coverage
- ❑ Employee (001)
- ❑ Employee & Spouse (002)
- ❑ Employee & Children (003)
- ❑ Family (004)

❑ **DECLINE MEDICAL (999/998)**

You must provide proof of other coverage to waive your medical coverage. Proof can be in the form of a copy of your current medical insurance card or you can complete the Coordination of Benefits/Waiver of Health coverage section below. You must work a minimum of 60 hours per pay period to qualify for the waiver reimbursement.

Dental Plans

- ❑ **Employers Dental Services** (104)
- ❑ **United Concordia Dental** (103)

Level of Coverage
- ❑ Employee (001)
- ❑ Employee & Spouse (002)
- ❑ Employee & Children (003)
- ❑ Family (004)

❑ **DECLINE DENTAL (110/998)**

Coordination of Benefit Or Waiver of Health Coverage Information

Must provide information regarding other available (**non-employee Maricopa County**) coverage

Medical Plan Name:	Plan Address	Plan Phone Number	I.D. #	Group #	Effective Date
Dental Plan Name:	**Plan Address**	**Plan Phone Number**	**I.D. #**	**Group #**	**Effective Date**

Employee and Dependent Coverage Information (Please attached information as requested below for additional Dependents.)

❑ Add ❑ Drop		**Employee** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: / EDS Dental Provider #:
❑ Add ❑ Drop	❑ Spouse ❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: / EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: / EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: / EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: / EDS Dental Provider #:

FOR OFFICE USE ONLY

❑ HRMS (H001)		❑ STAR (S002)		❑ Non Payroll (NP 003)	
❑ **CIGNA**	❑ **Health Select**	❑ **CIGNA**	❑ **Health Select**	❑ **CIGNA**	❑ **Health Select**
❑ Active (HACT)	❑ Active (ACH)	❑ Active (SACT)	❑ Active (SAC)	❑ Contract (NPCON)	❑ Contract (PCO)
❑ Public Safety (HPS)	❑ Public Safety (PSH)	❑ Residents (SRES)	❑ Residents (SRE)		
❑ Elected Officials (HEO)	❑ Elected Officials (EOH)	❑ Contract (SCON)	❑ Contract (SCO)		
❑ Contract (HCON)	❑ Contract (COH)				

Effective Date of Coverage: **Validation :**

Maricopa County Employee Health Initiatives, Employee Benefits Office
301 West Jefferson, Suite 201, Phoenix, AZ 85003
Phone: 602-506-1010 Fax: 602-506-2354
Email: BenefitsService@mail.maricopa.gov
Revised: September 2003

Basic Life with AD&D is 1 X Salary

Unum Life

(Paid by Maricopa County) (401)

Supplemental Life with AD&D

Unum Life

(Paid by employee) (402)

Non-Smoker	Smoker	
❑ 1 X Salary (001) ❑ 2X Salary (002) ❑ 3X Salary (003) ❑ 4X Salary (004) ❑ 5X Salary (005)	❑ 1 X Salary (011) ❑ 2X Salary (012) ❑ 3X Salary (013) ❑ 4X Salary (014) ❑ 5 X Salary (015)	❑ **Decline Supplemental Life**

Life Insurance Beneficiary Information for Basic and Supplemental Life

Examples of types of Beneficiary Designations*

- ✓ Primary- The entire benefit goes to the person(s) listed as primary .
- ✓ Secondary- In the event of the Primary beneficiary s death, the benefit would go to the person(s) listed as secondary
- ✓ Percentages- Must total 100%

Your legal spouse is entitled to a minimum 50% of the face value of your life insurance benefit. In the event that you do not select your spouse as a beneficiary or leave more than 50% of the benefit to a person or persons other than your spouse then your spouse **must** sign a spousal waiver or your beneficiary designation will not be considered valid.

***NOTE: Do not* list a dollar amount**

Beneficiary First Name	Beneficiary Last Name	Beneficiary Mailing Address	Date of Birth	Phone Number	Relationship	Benefit Designation*

Dependent Life

Unum Life

(Paid by employee) (403)

- ❑ Spouse $5,000 & each child $2,500 (001)
- ❑ Spouse $10,000 & each child $5,000 (002)
- ❑ **Decline Dependent Life**

Short Term Disability

Unum

(Paid by employee) (301)

- ❑ 40% (001)
- ❑ 50% (002)
- ❑ 60% (003)
- ❑ 70% (004)
- ❑ **Decline Short Term Disability**

Once your plans go into effect, you must have a Qualified Status Change as defined by the IRC Section 125 in order to modify your Medical, Dental or Spending Account plan elections. Information about the IRC section 125 plans can be found online at http://www.maricopa.gov/benefits.
It is the **responsibility** of the employee to submit the change request to the Benefits Office, by submitting an enrollment/ change form and attaching appropriate 3rd party documentation of the qualifying event within 31 calendar days of a status change. Retroactive changes will not be allowed unless otherwise required by law.

I authorize payroll deductions(from my paycheck) for the required premiums due for benefits I have chosen. I understand that these rates may be revised periodically. I certify that I have read and agree to abide by the information above.

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents as described in the Maricopa County Notice of Privacy Practices, with my health care providers, which could include, CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, AVESIS, Application Software Inc, (the flexible spending account administrator) and WHI in its role as Pharmacy Benefits Manager. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

Employee s Signature: **Date:**